January 25, 1999

There's No Such Thing as a Free Mandate

A Vote for 'Women's Health' is Actually Denying Care to Women (and Men)

Last October the Women's Health and Cancer Rights Act of 1998 was enacted as part of the omnibus spending bill [Public Law: 105-277]. Chiefly, this new provision in law requires consumers in ERISA health plans [ERISA is the federal law governing large and small employers providing self-insured healthcare benefits] to buy government-prescribed mastectomy and breast reconstruction coverage.

Many observers had predicted this mandate would increase health care costs only slightly. Yet early evidence suggests the law already may be cutting off access to health care for women and men alike. In a recent *Wall Street Journal* guest editorial, UnitedHealth Group chief medical officer Dr. Lee Newcomer reports the seemingly innocuous "explanation of benefits" mandate included in the act is already restricting access to care:

- UnitedHealth Group already covered the mandated benefits. Now the company must divert money from patient care in order to alert enrollees to a benefit they already had.
- "Sending bulk mail letters to [UnitedHealth's six million members] . . . could cost the company enough to pay for about 40 breast reconstruction surgeries."
- "It is simply impossible to cover every medical service available in unlimited quantities and keep the cost within the reach of average Americans."
- "With every new mandate I have two choices — raise premiums or cut coverage for another service from the plan."

Mandates require consumers to buy richer coverage but do nothing to help pay for it. Rather than cut off access to health care, ***Congress should make health care more affordable by giving* all *Americans (1) full deductibility of health insurance premiums and (2) unrestricted access to medical savings accounts.*** (Dr. Newcomer's column is reprinted on the reverse side.)

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THE WALL STREET JOURNAL.

MONDAY, JANUARY 11, 1999

Paperwork Is Bad for Your Health

Manager's Journal

By Lee Newcomer

This holiday season the government required me to write a letter to my four-year-old son, Michael. I awkwardly informed Michael that any woman in his health plan who undergoes breast cancer surgery is also covered for breast reconstruction surgery, plastic surgery for the unaffected breast to make it symmetrical, and devices that prevent swelling in the arm. You see, in addition to being Michael's father, I also am the medical director of his health plan.

Our health plan had covered all of these treatments since 1994. But under the Women's Health and Cancer Rights Act of 1998, even health plans already covering these newly mandated benefits must send a notification to every man, woman and child on its mailing list. UnitedHealthcare, the sponsor of Michael's plan, covers more than six million members. Sending bulk mail letters to those members, including Michael, could cost the company enough to pay for about 40 breast reconstruction surgeries.

Mike and I face other new paperwork, thanks to government mandates. When Mike wedged a calculator battery in his nose last fall, I paid a $50 copayment for emergency room care, the physician removed the battery, and our encounter with the health system was over. The Department of Labor intends to change that scenario. Under their recently proposed regulations, the department will require the health plan to send Michael an explanation of benefits—a summary of what was paid and what is owed for the visit—even if the bill is paid in full. One of the joys of prepaid health plans is the elimination of confusing bills to members. Now, as part of the Labor Department's interpretation of the patient bill of rights, the paper blizzard will resume.

It gets worse. If visiting the emergency room called for an authorization from the health plan, the new regulations require the plan to send a notice of coverage to the member and health-care provider even if there is no dispute about the coverage. At UnitedHealthcare, roughly 95% of all requests are approved and paid without disagreement. We pay some 85 million claims per year. If each mandated letter is mailed for the bulk rate of 17 cents, our company will spend $13.7 million for postage alone to comply with the regulations.

The real outrage is that these regulations divert money from medical care payments. Each year I attempt to balance providing the maximum amount of health-care coverage with keeping insurance costs affordable. It is simply impossible to cover every medical service available in unlimited quantities and keep the cost within the reach of average Americans.

The physician side of me wants to spend every available dollar providing medical care. I am angry about the millions of dollars I must waste on mandated paperwork that will not improve the health of a single patient. With every new mandate I have two choices—raise premiums or cut coverage for another service from the plan.

Legislators and regulators don't fully understand the price of their rules. Despite the prosperity of the U.S. economy, the Health Insurance Association of America reported a 4% increase in our uninsured population from 1996 to 1997. The primary reason for this tragic increase is that insurance costs are rising faster than incomes. The same report noted the highest uninsured rates occurred in states with the most regulations and mandates.

Medicare offers another vivid illustration. The Balanced Budget Act requires all Medicare beneficiaries to receive a brochure describing all of their coverage options, including Medigap insurance, HMO health plans and the standard fee-for-service program. The Health Care Financing Administration assessed the cost of the entire program to Medicare HMOs, even though they cover only 15% of all Medicare beneficiaries. My company paid approximately $9 million for this camouflaged tax. The fee-for-service plan's fund paid nothing.

On Jan. 1, I closed Medicare health plans in 86 counties across the nation because health-care costs and administrative expenses exceeded the premium paid by the government in those counties. Many of the seniors served by these plans lost coverage for prescription drugs upon returning to the fee-for-service plan. The $9 million spent on the informational brochure (a piece most seniors did not want and may not understand) would have allowed my company to continue operations in approximately 10 counties. The same $9 million could have provided 9,000 Medicare members with $1,000 each in prescription coverage.

Now a federal commission is considering new reform proposals for Medicare. Here's an idea: Give beneficiaries less paper and more care.

Dr. Newcomer is chief medical officer of UnitedHealth Group.